STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445302	A. BUILDING _____ B. WING _____	C 06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ELIZABETHTON	1641 HIGHWAY 19E ELIZABETHTON, TN 37643

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of hospital records, review of the facility's abuse policies and procedures, review of abuse training records, observation and interview, the facility failed to report an allegation of abuse to the State agency and failed to ensure the accused Certified Nursing Assistant (CNA) #1 received abuse training in accordance with the facility's abuse policies. The findings included: Resident #1 was admitted to the facility on May 30, 2006, with diagnoses including Peripheral Neuropathy, Dementia, Abnormal Loss of Weight, Neurogenic Bladder, Alcohol Abuse, Adult Failure to Thrive, Diabetes Mellitus, Cerebral Vascular Accident (CVA), Anxiety and Psychotic and Depressive Disorders. Medical record review of the Minimum Data Set (MDS) dated March 1, 2011, revealed the resident had severely impaired cognitive skills; had disorganized thinking and delusions; and was totally dependent on staff for all activities of daily living. Review of a hospital emergency room record dated February 18, 2011, revealed, "...Pt (patient) stated that...head was slammed into the bedrail	F 226	**F 226** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. All abuse allegations will be reported to the DOH by the ED or DON beginning May 18, 2011. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. Education was given to the ED and DON by the RDCS on the policy and procedure for reporting abuse allegations on May 18, 2011. All staff will be re-educated on abuse policy and procedure by the SDC on 6/14/11. All staff will attend annual in-services on abuse policy and procedure. All new hired staff will be educated on abuse policy and procedure by the SDC/DON/ADON beginning May 19, 2011. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** Abuse allegations will be immediately reported to the RVP and RDCS. RVP and RDCS will ensure policy and procedure is followed including reporting to the DOH.	7/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 6/14/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 15 2011

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F 226	Continued From page 1 by an...nurse (explitive) at the...nursing home...Closed head injury by history...stating...not taken care of properly at nursing home stating abuse...doesn't want to go back...side rails of bed...hit pt (with) head...small bruise...pump knot to head..." Continued review of the emergency room record dated February 18, 2011, revealed, "spoke (with) Administrator (of nursing home)...to discuss issue in length. Per (Administrator) CNA...turning pt in bed & head hit against side rail...CNA (#1 suspended during investigation...pt is 100% safe to return to N.H. (nursing home..." Review of the facility's investigation of the alleged incident revealed CNA #1 was suspended for three days while the facility interviewed staff and completed the investigation. The facility was not able to substantiate that CNA #1 was abusive to the resident. The CNA was allowed to return to work after the facility's investigtion had been completed. Continued review of the facility's investigation revealed staff were inserviced, after the alleged incident, on providing care to combative residents. Review of the facility's abuse policies and procedures revealed, "...12. Federal requirements mandate that facilities must ensure all allegations of abuse are reported immediately to their state agency...The 5-day report: Facilities must satisfy the federal requirement to report the results of an investigation within 5 working days from the date of the incident (or knowledge of the incident). Any report after that time will be considered out of compliance with regulation..."	F 226	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Beginning May 18, 2011 the Ed and DON will ensure compliance by reviewing daily concerns in morning meetings; the finding from the morning meeting will be reported to the monthly QI/PI committee. The committee consists of: M.D., D.O.N.,ADON, RSM, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping beginning June 14, 2011. Unless there is a reason for further observation, the monitoring will be concluded on August 9, 2011.	

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F 226	Continued From page 2 Continued review of the facility's abuse policies and procedures related to staff training and education revealed, "...Residents have the right to be treated by caring and compassionate staff who have adequate knowledge to appropriately respond to residents with diverse behaviors and dependencies, facilitating a protective environment for both residents and staff...On-going training about the protection of residents will be offered to facility staff at least quarterly..." Review of the facility's abuse training records for the previous twelve months revealed no record CNA #1 had been trained on abuse since May 2010. Observation on May 18, 2011, at 9:30 a.m., revealed the resident was lying in bed with the eyes open with an unintelligible speech pattern. The resident was not interviewable. Interview in the resident's room on May 18, 2011, at 9:30 a.m., with a Physical Therapist revealed the resident would "strike out at staff when turning...will strike them and cuss them. It takes two to help turn (resident)reposition..." Interview on May 18, 2011, at 10:20 a.m., with the Administrator in the conference room confirmed the allegation of abuse had not been reported to the State agency. Telephone interview on June 1, 2011, at 8:50 a.m., with CNA #1 revealed CNA #1 denied being abusive to resident #1 and denied knowledge or observation of a head injury at the time CNA #1 repositioned the resident. Continued interview	F 226		

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F 226	Continued From page 3 with CNA #1 revealed the resident was not combative or resistent to care during the alleged incident. Continued interview with CNA #1 revealed the CNA had been inserviced on abuse in August 2009, and confirmed the CNA had not been trained on abuse in 2010. C/O #27753	F 226		
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and interview, the facility failed to ensure a Certified Nursing Assistant (CNA) #1 had a current State license. The findings included: Review of the personnel file for CNA #1 on May 18, 2011, revealed the CNA was re-employed by the facility on August 10, 2009, and revealed the State license for CNA #1 expired on January 31, 2011. Interview on May 18, 2011, at 2:40 p.m., in the office, with the Human Resource personnel, confirmed CNA #1's license expired on January 31, 2011, and the CNA was working without a	F 499	**F 499** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. All personnel qualifications were audited and updated on May 19,2011. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. The HR director was educated by the ED on May 18, 2011 on the importance of maintaining updated licenses on qualified personnel. **What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** The HR director and ED completed a 100% audit to ensure all licenses and qualifications are up-to-date on May 19, 2011. HR director will update and maintain an active employee list with license expiration dates beginning May 19, 2011.	7/1/11

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F 499	Continued From page 4 current license. C/O #27753	F 499	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** The HR director will complete a 100% audit on all qualify staff quarterly. The finding from the quarterly audits will be reported to the monthly QI/PI committee. The committee consists of: M.D., D.O.N.,ADON, RSM, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping beginning June 14, 2011. Unless there is a reason for further observation, the monitoring will be concluded on August 9, 2011.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure an accurate and complete medical record was maintained for one (#2) of five residents reviewed. The findings included: Resident #2 was admitted to the facility on January 26, 2011, with diagnoses including Gunshot Wound with C7-T1 Fracture, Quadriplegia, Acute Respiratory Failure, Percutaneous Endoscopic Gastrostomy (PEG) tube and Tracheostomy. Medical record review of the Minimum Data Set (MDS) dated February 15, 2011, revealed the resident had intact	F 514	**F 514** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were effected by this practice. The TX nurse was immediately in-serviced by the DON on the importance of signing off of TARs and completing weekly skin assessments on May 18, 2011. **Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken?** All residents have a potential to be affected. TAR audits began on May 28, 2011 and weekly skin assessment audits began May 30, 2011. Education was given to wound care nurse by the DON on the importance of making sure TARS are completed and signed off on May 18, 2011.	7/1/11

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F 514	Continued From page 5 cognitive skills; was totally dependent on staff for all activities of daily living and had bilateral impairment in range of motion in both upper and lower extremities. Continued review of the MDS revealed the resident was admitted with two Unstageable Pressure Ulcers with necrotic tissue, the largest of which measured 12.5 cm (centimeters) X (times) 9.0 cm. Medical record review of the Care Area Trigger (CAT) for Pressure Ulcer dated February 15, 2011, revealed, "...admitted with two unstageable pressure ulcers on buttocks, contributing factors include immobility as well as incontinence and paralysis...care plan will be implemented to reflect skin issues as well as treatment interventions for issue..." Medical record review revealed the resident was discharged to the hospital on April 19, 2011, and did not return to the facility. Medical record review of a physician's order dated February 10, 2011, revealed, "...cleanse (left buttock)...NS (normal saline)...pat dry...Apply Revina...cover dry drsg (dressing)...(Change) qod (every other day)/prn (as needed)...cleanse (right buttock) (with) NS...pat dry...Apply Revina...cover dry drsg (change) qod/prn...Cleanse PEG site (with) NS...pat dry...Apply dry drsg qd (every day)/prn..." Medical record review of the Treatment Record (TAR) dated February 1-28, 2011, revealed no documentation wound care was provided to the PEG site on February 12 (Saturday), 13 (Sunday), 19 (Saturday), 20 (Sunday) and 21 (Monday), 2011, and no documentation wound	F 514	**What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?** TAR and weekly skin assessment audits will be competed by DON or ADON three times a week starting May 18, 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Beginning June 14, 2011 the DON and ADON audit findings will be reported to the monthly QI/PI committee. The committee consists of: M.D., D.O.N.,ADON, RSM, SDC, Social Service, Executive Director, Activities, HR, Admissions, Medical Records, Dietary, and Housekeeping beginning June 14, 2011. Unless there is a reason for further observation, the monitoring will be concluded on August 9, 2011.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 6 care was provided to the left or right buttock on February 13 and 20, 2011. Medical record review revealed the resident's skin condition was assessed by a nurse weekly. Medical record review revealed a Pressure Ulcer assessment was completed weekly by the Treatment Nurse, and the resident's risk for the development of Pressure Ulcers was assessed on a regular basis. The facility had placed a Clinitron bed under the resident, and the resident was care planned for turning and repositioning every two hours. Medical record review did not provide evidence the pressure ulcers deteriorated in February 2011, as a result of wound care not being documented on February 13 and 20, 2011. Medical record review and interview on May 18, 2011, at 2:15 p.m., in the conference room, with the Treatment Nurse, revealed the Treatment Nurse worked Monday through Friday, and nurses on the unit performed wound care on the weekends. Continued interview with the Treatment Nurse confirmed no documentation wound care was provided to the PEG site on February 12, 13, 19, 20 and 21, 2011, and no documentation wound care was provided to the left or right buttock on February 13 and 20, 2011. C/O #27753	F 514		